1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10776 — Reg. Dist. No. 10759

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Mead State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stevensville
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

091

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Ida	Belle	Aaron		Sept.	27	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		9/6/1868	91 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
?	?	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert Dorr	Abbott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT	Address
Unk.	NO	Deer's Mead Hospital	Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks ?
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive arteriosclerotic cardiovascular disease — Years ?
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, general — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Sept. 21, 1959, to Sept. 27, 1959, that I last saw the deceased alive on Sept. 27, 1959, and that death occurred at 8:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve, M.D. — ADDRESS (Street, city or town, state): Deer's Mead State Hospital — DATE SIGNED: 9/28/59

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/30/59	Dorchester Men. Park.	Cambridge, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Le Compte ~~Funeral~~ Funeral Service, Cambridge, Md. — 24a. REC'D BY REGISTRAR DATE: SEP 29 59 — 24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10777

CERTIFICATE OF DEATH

Reg. Dist. No. 10760

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 64 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: Box 4, Pineway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

091

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Amelia	Ellen	Adkins	9	30	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		9-10-84	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housework	Salisbury, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Smack	Rhoda Catherine ~~Smack~~ Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Deer's Head Hospital Records (Address)
unknown		

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary edema	30 min.
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic cardiovascular disease	Years
DUE TO (c)	Arteriosclerosis, general	"

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-28-59, 1959, to 9-30, 1959, that I last saw the deceased alive on 9-30, 1959, and that death occurred at 3:25 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldre, M.D. — ADDRESS (Street, city or town, state): Deer's Head Hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): Dr. L. V. Maldre — Salisbury — Maryland

1

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10-2-59	Bethel Cemetery -Walston-R.D.#	Salisbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY MARYLAND	OCT 5 '59	Arthur J. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10778 — Reg. Dist. No. 10761

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Pittsville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: Baker

4. DATE OF DEATH: Month: September — Day: 13 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1900

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee

10b. KIND OF BUSINESS OR INDUSTRY: Nurserey

11. BIRTHPLACE (State or foreign country): DeLaware

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Baker

14. MOTHER'S MAIDEN NAME: Lavinia Messick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-07-2117

INFORMANT: Mrs. Olive Vickers Baker, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug, 19 57, to Sept 13, 19 59, that I last saw the deceased alive on Sept 13, 19 59, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Beardsley, M.D. — ADDRESS (Street, city or town, state): Maryland Ave. Salisbury, Maryland — DATE SIGNED: 9/13/59

PHYSICIAN'S NAME (Type): Earl Beardsley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/14/1959 — 22c. NAME OF CEMETERY OR CREMATORY: Grace Cemetery — 22d. LOCATION (City, town, or county) (State): Pittsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Norman T. Baker — ADDRESS: Hill & Johnson Co. Salisbury, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 16 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krantz

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10762

CERTIFICATE OF DEATH

10779 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne 19X-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Paul Middle R. Last Brown
4. DATE OF DEATH Month September Day 17 Year 19 59

5. SEX MALE
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH Jan. 11, 1898
9. AGE (In years last birthday) 61 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James Brown
14. MOTHER'S MAIDEN NAME Sarah Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Lola Brown Address Princess Anne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral pneumonia
502.0
DUE TO (b) Chronic emphysema, Asthma Bronchitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 1 wk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Subtotal gastrectomy for complete pyloric Stenosis
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 31, 1959, to SEPT 17, 1959, that I last saw the deceased alive on Sept. 17, 1959, and that death occurred at 12:15 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE William A. Hobbs Jr. M.D.
ADDRESS (Street, city or town, state) Salisbury Md.
DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/19/59
22c. NAME OF CEMETERY OR CREMATORY Oliver
22d. LOCATION (City, town, or county) (State) Rural Princess Anne Md.

23. FUNERAL DIRECTOR'S SIGNATURE Jones Dennison ADDRESS Princess Anne Md
24a. REC'D BY REGISTRAR DATE SEP 22 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10764

CERTIFICATE OF DEATH

10780

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 90 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield
d. STREET ADDRESS: Jacksonville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1939.2

091

3. NAME OF DECEASED (Type or print): First: John — Middle: Henry — Last: Byrd

4. DATE OF DEATH: Month: Sept. — Day: 23 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/10/1879

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector--Retired

10b. KIND OF BUSINESS OR INDUSTRY: Tidewater Fisheries

11. BIRTHPLACE (State or foreign country): Crisfield, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Byrd

14. MOTHER'S MAIDEN NAME: Rachel Ayres

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Deer's Head Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

420.0

DUE TO (b): General Arteriosclerosis — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral direct inguinal hernia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 25, 1959, to Sept. 23, 1959 that I last saw the deceased alive on Sept. 23, 1959, and that death occurred at 6:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly, M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital, Salisbury, Maryland — DATE SIGNED: 9/23/59

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept.26,1959

22c. NAME OF CEMETERY OR CREMATORY: Sunnyridge Cemetery

22d. LOCATION (City, town, or county) (State): Crisfield, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Bradshaw & Sons--Crisfield, Md.

24a. REC'D BY REGISTRAR DATE: SEP 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10830

CERTIFICATE OF DEATH

10765
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARDELA RD2
c. LENGTH OF STAY IN 1b: 5 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MARDELA-ATHOL ROAD

2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: DELAWARE
b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
d. STREET ADDRESS: CLAYTON AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROY Middle H. Last CALLAWAY
4. DATE OF DEATH: Month SEPT. Day 30 Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 14, 1878
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JOHN H. CALLAWAY
14. MOTHER'S MAIDEN NAME: ETTA WEBB
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: GEORGE G. CALLAWAY, RD 2 MARDELA, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ADVANCED ARTERIOSCLERIOTIC HEART DISEASE
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG. ____, 1959, to SEPT. 30, 1959, that I last saw the deceased alive on SEPT. 30, 1959, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. P. Ellis M.D.
ADDRESS (Street, city or town, state): LAUREL, DELAWARE
DATE SIGNED: 10/1/59
PHYSICIAN'S NAME (Type): W. P. ELLIS, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/3/59
22c. NAME OF CEMETERY OR CREMATORY: LAUREL HILL CEMETERY
22d. LOCATION (City, town, or county) (State): LAUREL, DELAWARE

23. FUNERAL DIRECTOR'S SIGNATURE: Harvey F. Williams
ADDRESS: FEDERALSBURG, MARYLAND
24a. REC'D BY REGISTRAR DATE: OCT 5 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Hearn

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10781

CERTIFICATE OF DEATH

10766
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 847 Brown St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 847 Brown St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
JOHN	JOSEPH	CEDARS	SEPT.	6th	19 59

5. SEX	6. COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min
Male	White		Oct.4, 1897	61 yrs	11	2		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter	House Painting	Canada	Canada

13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
John Cedars	Mary -(Unk)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
Unk		Mrs. Marion L. Cedars (Wife) 847 Brown St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardiovascular

DUE TO (c): Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from _____, 19____, to Sept 6, 19 59 that I last saw the deceased alive on _____, 19_____, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A C Mitchell M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: Sept. 8 /59

PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell — Maryland Ave. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town or county) (State)
Burial	Sept. 11 /59	Parsons Cemetery	Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY SALISBURY MARYLAND	SEP 10 '59	Arthur E. Hearn

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10782

CERTIFICATE OF DEATH

10767
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: VIRGINIA
b. COUNTY: ACCOMAC
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ASSAWOMAN
d. STREET ADDRESS: ASSAWOMAN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First [illegible] Middle S. Last CHESSER

4. DATE OF DEATH: Month SEPTEMBER Day 1 Year 1959

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB 19 1888
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Produce Picker
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewell Chesser
14. MOTHER'S MAIDEN NAME: Annie Chesser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 231-09-3976
INFORMANT: Bobby Darby Address: Assawoman, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 HOURS
454X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) THROMBOSIS OF AORTIC GRAFT — 17 HOURS
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/31, 1959, to 9/1, 1959, that I last saw the deceased alive on 9/1, 1959, and that death occurred at 5:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John M. Blexom III M.D. — ADDRESS (Street city or town, state): Salisbury, Maryland — DATE SIGNED: 9/1/1959
PHYSICIAN'S NAME (Type): JOHN M. BLEXOM III — SALISBURY, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: SEPT. 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: ASSAWOMAN Chapel
22d. LOCATION (City, town, or county) (State): ASSAWOMAN, VA.

23 FUNERAL DIRECTOR'S SIGNATURE: [illegible] FOR FUNERAL HOME — ADDRESS: TEMP, VA.
24a. REC'D BY REGISTRAR DATE: SEP 11 '59
24b. REGISTRAR'S SIGNATURE: Collins S. Kinsey

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 22, Film G249 10/2/59 iwk

CERTIFICATE OF DEATH

10783 — Reg. Dist. No. 10769

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 162 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 11 Park Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: M. — Last: Coleman

4. DATE OF DEATH: Month: September — Day: 17th, — Year: 19 59

5 SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 30, 1878
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic worker
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Timothy Keene
14. MOTHER'S MAIDEN NAME: Cornish

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO:
INFORMANT — Address: Deer's Head State Hospital Records, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(b): Arteriosclerosis, general — Years
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia, cause undetermined

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 8, 19 59, to Sept. 17, 19 59, that I last saw the deceased alive on September 17, 19 59, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dr. V. Juerman. M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 9/17/59

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/23/59
22c NAME OF CEMETERY OR CREMATORY: Waugh Cemetery
22d. LOCATION (City, town, or county) (State): Cambridge, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: H. Lee Sinclair, Cambridge, Md.
24a. REC'D BY REGISTRAR DATE: SEP 29 '59
24b. REGISTRAR'S SIGNATURE: Clarence E. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10784 — Reg. Dist. No. 10770

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 10 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1101 S. Division St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 1101 S. Division St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUISE — Middle MILLER — Last COLVIN

4. DATE OF DEATH: Month September — Day 14 — Year 1959

5. SEX: FEmale

6. COLOR OR RACE: WHite

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 14, 1891

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR — Months — Days
IF UNDER 24 HRS. — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer

10b. KIND OF BUSINESS OR INDUSTRY: Retail

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Miller

14. MOTHER'S MAIDEN NAME: Louise B rinker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): ******

16. SOCIAL SECURITY NO.:

17. INFORMANT: John F. Colvin — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): " Insufficiency
DUE TO (c): Obesity - Diabetes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/14, 1959 to 9/14, 1959 that I last saw the deceased alive on 9/14, 1959, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W B Smith M.D. — ADDRESS (Street, city or town, state): Med. Center Alby Md — DATE SIGNED: 9/16/59.

PHYSICIAN'S NAME (Type): William B. SMith, M.D. — Medical Center, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 9/17/1959
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co., Salisbury, MAryland

24a. REC'D BY REGISTRAR DATE: SEP 21 '59

24b. REGISTRAR'S SIGNATURE: Arthur H. Krauss

George C. Hill Jr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1 X

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10785 — Reg. Dist. No. 10771

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Belair 1232.2
d. STREET ADDRESS: 421 Barnes St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: GILBERT — Last: Cooley
4. DATE OF DEATH: Month: 9- — Day: 5- — Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 19 1889
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney at Law
10b. KIND OF BUSINESS OR INDUSTRY: Law
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: AMBROSE COOLEY
14. MOTHER'S MAIDEN NAME: CARRIE A. HUGHES
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WORLD WAR I
16. SOCIAL SECURITY NO.: 213-38-6380
17. INFORMANT — Address: MRS. ELSIE K. C. COOLEY, BELAIR MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion	Sudden
DUE TO (b)	Arteriosclerotic heart disease	10 yrs
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 9-5-59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7-SEPT.-1959
22c. NAME OF CEMETERY OR CREMATORY: ROCK RUN, CEM.
22d. LOCATION (City, town, or county): HARFORD (State): MD
23. FUNERAL DIRECTOR'S SIGNATURE: R. MADISON MITCHELL — ADDRESS: HAVRE DE GRACE MD.
24a. REC'D BY REGISTRAR — DATE: SEP 9 '59
24b. REGISTRAR'S SIGNATURE: Clifton L. Kirwan

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10772

Reg. Dist. No. 10786

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Delaware b. COUNTY Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean View
d. STREET ADDRESS Ocean View
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First David Middle — Last Dawson
4. DATE OF DEATH Month 9 Day 1 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10-4-02
9. AGE (In years last birthday) 56 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant
10b. KIND OF BUSINESS OR INDUSTRY Store
11. BIRTHPLACE (State or foreign country) Aberdeen-Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Dawson
14. MOTHER'S MAIDEN NAME Jean Fraser
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 192-09-0523
17. INFORMANT Address Mary Dawson - Ocean View - Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH —
DUE TO (b) Hypertension C.V. Disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer — M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type) Earl L. Royer
DATE SIGNED 9-1-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/4/59
22c. NAME OF CEMETERY OR CREMATORY Presbyterian Church
22d. LOCATION (City, town, or county) (State) Ocean View - Del.
23. FUNERAL DIRECTOR'S SIGNATURE Donald James — ADDRESS Millsboro - Del.
24a. REC'D BY REGISTRAR DATE SEP 8 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krana

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10787 — Reg. Dist. No. 10773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 837 Cooper St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARVIN — Middle HAMILTON — Last DENNIS
4. DATE OF DEATH: Month 9 — Day 5 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 6, 1910
9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Goolie Dennis
14. MOTHER'S MAIDEN NAME: Lizzie Tindall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 220-10-960[illegible]
17. INFORMANT — Address: Mrs Elizabeth S. Dennis, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Dysfunction — INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 5, 19 59 to Sept 5, 19 59 that I last saw the deceased alive on Sept 5, 19 59, and that death occurred at [illegible] M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm D Gray M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: 9/8/59

PHYSICIAN'S NAME (Type): Dr. Wm. D. Gray 334 Camden Ave., Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/8/59
22c. NAME OF CEMETERY OR CREMATORY: Spring Hill Mem. Gardens
22d. LOCATION (City, town, or county) (State): Spring Hill, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR — DATE: SEP 11 59
24b. REGISTRAR'S SIGNATURE: Clifford L. Truland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10774

10788

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: Sussex ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: RD 1
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First Ethel — Middle — Last Dickenson

4. DATE OF DEATH: Month September — Day 2 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Oct. 7, 1881

9. AGE (In years last Birthday): 77 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Levin J. Hill

14. MOTHER'S MAIDEN NAME: Sallie Ann Culver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: James H. Dickerson, Laurel Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 11 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b):

DUE TO (c): Arteriosclerosis, Generalized — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Secondary Infection.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/25, 1959 to 9/2, 1959 that I last saw the deceased alive on 9/1, 1959, and that death occurred at 5:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus S. Gardner Jr. M.D. — ADDRESS (Street, city or town, state): Pine Bluff Rd. — DATE SIGNED: 9/2/59

PHYSICIAN'S NAME (Type): Rufus S. Gardner Jr. — Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/4/59

22c. NAME OF CEMETERY OR CREMATORY: Odd Fellows Cem

22d. LOCATION (City, town, or county) (State): Laurel, Del

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: J. Harvey Williamson, Federalsburg

24a. REC'D BY REGISTRAR DATE: SEP 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur J. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, if disposition is by burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

Item. 18 & 19 Film 250 10-14-59 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11961

10789 Item 14 Film G250 10-14-59 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1031 Lake St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: Woodland — Last: Dixon

4. DATE OF DEATH: Month: 9-28-59 — Day — Year: 19

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 19[illegible]

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Wicomico Co

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Unknown ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-30-73

17. INFORMANT: Address: Mary Benson

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): A S C V D — Years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

9-30-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 31-59

22c. NAME OF CEMETERY OR CREMATORY: Green Acres

22d. LOCATION (City, town, or county) (State): Salisbury Md

23. FUNERAL DIRECTOR'S SIGNATURE: Brooks McCash — ADDRESS:

24a. REC'D BY REGISTRAR DATE: OCT 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10831

CERTIFICATE OF DEATH

Reg. Dist. No. 10775

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: R.D.# 3 Delmar Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury(Rural)
d. STREET ADDRESS: R.D.# 3Delmar Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JULIA — Middle A. — Last ELLIOTT

4. DATE OF DEATH: Month SEPT. — Day 23rd — Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 27,1889
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months 4 — Days 28
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Delmar(Wico.Co.) Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Nutter Oliphant
14. MOTHER'S MAIDEN NAME: Mary F. (No Record)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
INFORMANT: Mr.George Oliphant(Nephew) Mr.Preston Oliphant(Nephew)
Address: R.D.# Sal.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3days
DUE TO
352X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Essential Hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/20, 1959 to death, 19___, that I last saw the deceased alive on 9/23/59 19___, and that death occurred at 8:20P M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED
ACTUAL SIGNATURE: Ernest M. Larmore M.D. — Sept. 25/59
PHYSICIAN'S NAME (Type): Dr.Ernest M.Larmore — Delmar, Delaware (VI-6-8521) PHONE

22a. BUR AL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sep.26,1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City town, or county) (State): Salisbury,Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: SEP 29 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10790

CERTIFICATE OF DEATH

Reg. Dist. No. 10776

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 522 Rose Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Helen — Middle: B. — Last: Fooks
4. DATE OF DEATH Month: September — Day: 9 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 29 1915
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. Fooks
14. MOTHER'S MAIDEN NAME: Lilian J. Roy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 213-14-7462
INFORMANT: Vera Dennis — Address: 522 Rose Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated Lupus Erythematosus — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a m / p m — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 7, 1959 to Sept 9, 1959 that I last saw the deceased alive on Sept. 9, 1959, and that death occurred at 11:30 AM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE David J. Gilmore M.D. — Medical Center
PHYSICIAN'S NAME (Type) DAVID J. GILMORE, M.D. — SALISBURY, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 13, 1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons
22d. LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Winton F. Stewart — ADDRESS: Salisbury Md.
24a. REC'D BY REGISTRAR DATE: SEP 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10791

CERTIFICATE OF DEATH

Reg. Dist. No. 10777

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1230 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
d. STREET ADDRESS: 123 Dodson Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Blanche — Middle: H. — Last: Gates

4. DATE OF DEATH: Month: September — Day: 6 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 9, 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): St. Michaels, Md.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Perry Huskins

14. MOTHER'S MAIDEN NAME: Margaret Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 217-03-6095A

17. INFORMANT: Hospital Records, Salisbury, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Diabetes mellitus — INTERVAL BETWEEN ONSET AND DEATH: Years

260X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic cardiovascular disease; arteriosclerosis, general

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 25, 1956 to Sept. 6, 1959, that I last saw the deceased alive on Sept. 6, 1959, and that death occurred at 11:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Juerman M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 9/7/59

PHYSICIAN'S NAME (Type): V. Juerman, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/11/59
22c. NAME OF CEMETERY OR CREMATORY: St. Michaels Cem.
22d. LOCATION (City, town, or county) (State): St. Michaels Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James E. Bachtell
ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: SEP 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The Law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15E 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10792

CERTIFICATE OF DEATH

10778

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY: Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury

LENGTH OF STAY (In this place): Since 9/17/59

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pine Bluff State Hospital, Salisbury, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke

STREET (If rural give location): RFD #2

3. NAME OF DECEASED (Type or Print): Edwin (First) S. (Middle) Gray (Last)

4. DATE OF DEATH: Sept. 23, 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Dec. 25, ~~1886~~ 1888	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joshua Gray	Esther Henderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	---	None	Records of Pine Bluff State Hospital

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

ANTECEDENT CAUSE(S) DUE TO (B):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 17, 1959, to Sept. 23, 1959, that I last saw the deceased alive on Sept. 22, 1959, and that death occurred at 7:55 M, from the causes and on the date stated above.

SIGNATURE Edward P. Ritchings M.D. — **ADDRESS** (Street, city, town, state) Salisbury, Md. — **DATE SIGNED** 9/23/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY	LOCATION (City, town, or county) (State)
Burial	9-25-59	Holly Grove Mennonite	Rural Westover, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS
SEP 28 59	Esther S. Truitt	Robert H. Watson, Pocomoke, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10793 Reg. Dist. No. 10779

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 mons.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 235 North Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSSELLA Middle HUSTON Last GREAF

4. DATE OF DEATH: Month 9 Day 29 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 27, 1885
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Irving R. Huston
14. MOTHER'S MAIDEN NAME: Louise C. Larrimore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): ******
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Carl T. Graef Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Vascular Accident
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Hypertensive C.V. disease
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1/10/58 to 9/29/59, that I last saw the deceased alive on 9/29/59, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm B Smith M.D. ADDRESS (Street, city or town, state): Med. Arts Bldg. Salisbury Md. DATE SIGNED: 9/30/59

PHYSICIAN'S NAME (Type): William B. Smith, M.D. Medical Center, Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/2/1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: OCT 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Kunkel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10832 — Reg. Dist. No. 10780

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D.# (Quantico Rd)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico (Rural)
d. STREET ADDRESS: R.D.#(Quantico Rd)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MYRTLE — Middle LEE — Last GRIFFIN
4. DATE OF DEATH: Month SEPT. — Day 6th — Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 15, 1921
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Dress Factory (Presser)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Clara, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George Hayward
14. MOTHER'S MAIDEN NAME: Mae Austin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Fancy Abbott (Daughter) Address: Baysinger Trailer Camp Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bullet Wound of Brain — INTERVAL BETWEEN ONSET AND DEATH: Instant
976X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot with 35 Cal Rifle
20c. TIME OF INJURY: Hour 9 (a. m. / p. m.) — Month, Day, Year 9-6 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Quantico (County): Wicomico (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☒.

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 8 1959
EXAMINER'S NAME (Type): Dr. Earl L. Royer

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 9, 1959
22c. NAME OF CEMETERY OR CREMATORY: Bivalve Church Cemetery
22d. LOCATION (City, town, or county) (State): Bivalve, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: SEP 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10833 **CERTIFICATE OF DEATH** 10781

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockawalkin
c. LENGTH OF STAY IN 1b: 1 Hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hebron
d STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): HENRY Lee LEE Harris
4. DATE OF DEATH: Month 9 Day 10 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 4, 1883
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Benjamin F. Harris
14. MOTHER'S MAIDEN NAME: Joella Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16 SOCIAL SECURITY NO.: none
17. INFORMANT Address: Mrs. Edith Taylor Harris, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1952 to 9/10/1959, that I last saw the deceased alive on 9/10/1959, and that death occurred at 12:05PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: H A Briele M.D.
ADDRESS (Street, city or town, state): Salisbury, MAryland
DATE SIGNED: 9/10/59
PHYSICIAN'S NAME (Type): Dr. Henry A. Briele Medical ceheter Salisbury, MAryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/13 59
22c. NAME OF CEMETERY OR CREMATORY: Siloam Cemetery
22d. LOCATION (City, town or county) (State): Siloam, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland
24a. REC'D BY REGISTRAR DATE: SEP 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur W. Timms

M. D. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10794 — 10782 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 24 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: 337 Hampton Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARY Middle — Last HAYWARD

4. DATE OF DEATH: Month SEPTEMBER Day 1 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: COLORED
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 16-1928
9. AGE (In years last birthday) 30 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory worker
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Marion Somerset Co Md
12 CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Samuel Pollitt
14. MOTHER'S MAIDEN NAME: Tilly Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-24-2176
INFORMANT: Audrey Haywood Address: Princess Anne Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): generalized Sepsis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) generalized peritonitis
DUE TO
(c) sub-hepatic abscess
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Post op. Tubal Ligation - multipara
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-11- 1959, to 9-1- 1959, that I last saw the deceased alive on 9-1- 1959, and that death occurred at 10:22 P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE Robert Lee Bivens M.D
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept 6-1959
22c. NAME OF CEMETERY OR CREMATORY Oakville Md
22d. LOCATION (City, town, or county) (State) Princess Anne Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles H Ward Marion Md
24a. REC'D BY REGISTRAR DATE SEP 11 '59
24b. REGISTRAR'S SIGNATURE Willie S Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10795 — Reg. Dist. No. 10783

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 85 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bozman
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: James — Middle: Franklin — Last: Henry

4. DATE OF DEATH: Month: September — Day: 10 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: August 8, 1917
9 AGE (In years last birthday): 42 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lankford Henry
14. MOTHER'S MAIDEN NAME: Mary Ann Palmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-10-3852
17. INFORMANT — Address: Hospital Records, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of esophagus with metastases — INTERVAL BETWEEN ONSET AND DEATH: ?

150x

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 17, 1959, to Sept. 10, 1959, that I last saw the deceased alive on Sept. 10, 1959, and that death occurred at 5:45A M, from the causes and on the date stated above

ACTUAL SIGNATURE: V. Juerman M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 9/10/59

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 14, 1959
22c. NAME OF CEMETERY OR CREMATORY: Thomas memorial
22d LOCATION (City, town, or county) (State): St. Michaels Md

23. FUNERAL DIRECTOR'S SIGNATURE: L. Hamilton Harrison — ADDRESS: St. Michaels Md

24a. REC'D BY REGISTRAR DATE: SEP 15 '59
24b REGISTRAR'S SIGNATURE: Catherine S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10796 — Reg. Dist. No. — 10784

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sp.Hill Pr. Sani.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 16 Salisbury
d. STREET ADDRESS: N. Div. St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH — Middle LONG — Last HEROLD

4. DATE OF DEATH: Month 9 — Day 22 — Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: July 21, 1880
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: School Teacher
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Clay Long
14. MOTHER'S MAIDEN NAME: Elmira Tunnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: Mrs. Wm.S. Mere Salisbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 3-4 yrs

4420

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__ to 9-22, 1959, that I last saw the deceased alive on 9-21, 1959, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Phillip A Insley M.D. — ADDRESS (Street, city or town, state): Salisbury Maryland — DATE SIGNED: 9/24/59

PHYSICIAN'S NAME (Type): Dr. Phillip A. Insley Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/24/59
22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
22d LOCATION (City, town, or county) (State): Lewis, Del.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Md.
24a REC'D BY REGISTRAR DATE: SEP 28 '59
24b REGISTRAR'S SIGNATURE: Arthur L Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10834

CERTIFICATE OF DEATH

10785
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Center St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar (Rural)
d STREET ADDRESS R.D.# 3
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First PAUL Middle C. Last HILL
4. DATE OF DEATH Month SEPT. Day 20th Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH March 10,1923
9. AGE (In years last birthday) 36 yrs
IF UNDER 1 YEAR Months 6 Days 10 IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber Cutter
10b. KIND OF BUSINESS OR INDUSTRY Timber
11. BIRTHPLACE (State or foreign country) Melsons(Wico.Co) Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Harland W. Hill
14. MOTHER'S MAIDEN NAME Lula Ethel Figgs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) W.W.#II
16 SOCIAL SECURITY NO.
INFORMANT Mrs. Martha J. Hill (Wife) Address R.D.#3 Delmar Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH instant

DUE TO (b) Coronary atheromatosis — 2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Obesity

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1st, 1959, to Sept 20, 1959, that I last saw the deceased alive on Sept. 17, 1959, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE L.V. Sohler M.D
ADDRESS (Street, city or town, state) 303 East St.
DATE SIGNED Sept. 21 1959

PHYSICIAN'S NAME (Type) Dr. L.V. Sohler Delmar, Maryland

22a. BUR'L, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF Sept.23/1959
22c. NAME OF CEMETERY OR CREMATORY Melsons Cemetery
22d LOCATION (City, town, or county) (State) Melsons(Wico.Co.) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE SEP 24 '59
24b. REGISTRAR'S SIGNATURE C. Elton Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10786

CERTIFICATE OF DEATH

10797 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 48 Hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
d. STREET ADDRESS: Clarke Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First STEVEN Middle COLE Last HOWARD

4. DATE OF DEATH: Month September Day 1 Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 30-1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR Months — Days 2 — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM THOMAS HOWARD III

14. MOTHER'S MAIDEN NAME: HELEN COLE THOMAS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

INFORMANT Address: W. T. HOWARD III, POCOMOKE CITY, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Erythroeal Vascular Collapse During Exchange Transfusion — INTERVAL BETWEEN ONSET AND DEATH
770.0
DUE TO
(b): Hemolytic Disease of the Newborn due to Rh incompatability — 48 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/30, 19 59 to 9/1, 19 59, that I last saw the deceased alive on 9/1, 19 59, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lloyd C Kelly M.D. ADDRESS (Street, city or town, state): Mutual Center DATE SIGNED: 9/1/59

PHYSICIAN'S NAME (Type): Salisbury Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9-2-59

22c. NAME OF CEMETERY OR CREMATORY: BAPTIST CEMETERY

22d. LOCATION (City, town, or county) (State): POCOMOKE CITY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Henry M. Watson ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR DATE SEP 8 '59

24b. REGISTRAR'S SIGNATURE: Catherine L. Kramer

20822 284XUA

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10798

CERTIFICATE OF DEATH

Reg. Dist. No. 10787

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 231 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 601 Decatur Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Wallace — Middle: Duane — Last: Humes

4. DATE OF DEATH: Month: September — Day: 7 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 22, 1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Meadville, Pa.

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Samuel Duane Humes

14. MOTHER'S MAIDEN NAME: ~~Rhoberx~~ Elizabeth Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Edwin F. Humes (Brother) San Antonio, Texas
(Hospital Records, Salisbury, Md.)
321 Elizabeth Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Arteriosclerosis, general

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid arthritis, multiple

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from January 19 19 59, to Sept. 7, 1959, that I last saw the deceased alive on Sept. 7, 19 59, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly M.D.

ADDRESS (Street, city or town, state): Deer's Head State Hospital

DATE SIGNED: 9/7/59

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D.

Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 10/59

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: SEP 10 '59

24b. REGISTRAR'S SIGNATURE: Esther L. Howe

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10788

CERTIFICATE OF DEATH

10799

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION):

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury Md
d. STREET ADDRESS: 16 Twilley Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence Middle: S. Last: Hutt

4. DATE OF DEATH: Month: 9 Day: 14 Year: 1959

5. SEX: Mal

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 65 1894

9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Snow Hill Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sidney Hutt

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO: 214-10-9581

17. INFORMANT: Margit Palmer Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour ___ a.m. p.m. Month ___ Day ___ Year 19___

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 56, to 9-14, 19 59, that I last saw the deceased alive on 9-12, 19 59, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip A. Tinsley M.D.
ADDRESS (Street, city or town, state): Salisbury Md
DATE SIGNED: 9-18-59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-20-59
22c. NAME OF CEMETERY OR CREMATORY: Green Hoven Cem
22d. LOCATION (City, town, or county) (State): Salisbury Md

23. FUNERAL DIRECTOR'S SIGNATURE: Brooks McWest
ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 25 '59
24b. REGISTRAR'S SIGNATURE: Wilbur L. Trunk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10835

10789

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 81 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 408 Elizabeth

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Delmar
d. STREET ADDRESS: 408 Elizabeth
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Walter — Middle Gilbert — Last Insley

4. DATE OF DEATH: Month Sept. — Day 24th — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 28, 1878

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: Bakery

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jas. P. Insley

14. MOTHER'S MAIDEN NAME: Biddy Messick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.: 577-20-0804

17. INFORMANT — Address: Mary Insley, Delmar, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis of liver
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH: 4 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to Sept 23rd 1957, that I last saw the deceased alive on Sept 23rd, 1957, and that death occurred at 5:30 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: L.V. Sohler M.D

ADDRESS (Street, city or town, state): 303 Zion Rd. Salisbury, Md. 21801

DATE SIGNED

PHYSICIAN'S NAME (Type): L.V. Sohler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-26-59

22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W.S. Mavel Co - Delmar, Del

24a. REC'D BY REGISTRAR DATE SEP 28 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Kimes

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10790

CERTIFICATE OF DEATH

10800

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fruitland
d. STREET ADDRESS: S. Division St. Ext.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alfred — Middle: — Last: Johnson

4. DATE OF DEATH: Month: September — Day: 2 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 20, 1883

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Worcester Co. Maryland

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: John Henry Johnson

14. MOTHER'S MAIDEN NAME: Mary Ruark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unk
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Daisy Johnson (Wife) — Address: S. Div. St. Ext. Fruitland, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, Coron. — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 7-1, 1959, to 9-2, 1959 that I last saw the deceased alive on 9-2, 1959, and that death occurred at 6:00 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilber R. Ellis Jr. M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 9-2-59

PHYSICIAN'S NAME (Type): Dr. Wilber R. Ellis Jr. — Medical Center-Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 5, 1959

22c. NAME OF CEMETERY OR CREMATORY: Olivet Cemetery

22d. LOCATION (City, town, or county) (State): Worcester Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: SEP 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Hearn

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10803

CERTIFICATE OF DEATH

10791
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marion Station
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Violetta — Middle: — Last: Jones

4. DATE OF DEATH: Month: September — Day: 27 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG 1. 1959

9. AGE (In years lost birthday): NO yrs. — IF UNDER 1 YEAR: Months: 1 Days: 26 — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY: INFANT

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL CORBIN

14. MOTHER'S MAIDEN NAME: MARTHA JONES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO: NONE

INFORMANT: ROBERT CORBIN, Address: MARION, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH:

772.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia and Malnutrition

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on _____, 19_____, and that death occurred at 6:03 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: William C. Morgan M.D.

PHYSICIAN'S NAME (Type): WILLIAM C. MORGAN — SALISBURY, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: SEPT. 25 1959

22c. NAME OF CEMETERY OR CREMATORY: PRIVATE FAMILY

22d. LOCATION (City, town, or county) (State): MARION, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: BRADSHAW & SONS — ADDRESS: CRISFIELD, MD

24a. REC'D BY REGISTRAR: DATE OCT 5 '59

24b. REGISTRAR'S SIGNATURE: Curtis A. Smith

2079193XU4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10792 Reg. Dist. No.

10802

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 678 W. Main St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First William Middle L Last Jones
4. DATE OF DEATH Month September Day 12 Year 1959

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-22-1924
9. AGE (In years last birthday) 34 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Richardson
14. MOTHER'S MAIDEN NAME Nellie Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Miss Peggy Jones, 687 W Main St Salisbury Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Congestion
DUE TO (b) Pulmonary Tuberculosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 1 day Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 7, 1948 to 12 Sept., 1959, that I last saw the deceased alive on 12 Sept., 1959, and that death occurred at 6:45 P. M. from the causes and on the date stated above.
ACTUAL SIGNATURE A. T. Purnell, M.D. ADDRESS (Street, city or town, state) 612 W Main DATE SIGNED 12 Sept 59.
PHYSICIAN'S NAME (Type) Salisbury Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9-16-59
22c. NAME OF CEMETERY OR CREMATORY Green Acre Memorial Cem.
22d. LOCATION (City, town, or county) (State) Salisbury Md.

23 FUNERAL DIRECTOR'S SIGNATURE Thornton B. Jolley Memorial Chapel ADDRESS Salisbury, Md
24a. REC'D BY REGISTRAR DATE SEP 18 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Filed 9-24-59 et

10803

CERTIFICATE OF DEATH

Reg. Dist. No. 10793

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PITTSVILLE (Rural)
d. STREET ADDRESS: R.D.#
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARGARET (MAGGIE) Middle LAURA / Florence Lost LANK

4. DATE OF DEATH: Month SEPTEMBER Day 17 Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 3, 1880

9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR Months 3 Days 14 IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Martin Hancock

14. MOTHER'S MAIDEN NAME: Laura White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

INFORMANT: Mrs. (Myrtle) Frank Hudson — Niece — Address: R.D.# Pittsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Mesentery artery Embolus — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
DUE TO (b): Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on 9/17, 1959, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William H Fisher M.D — ADDRESS (Street, city or town, state): Salisbury Md. — DATE SIGNED: Sept 17 1959

PHYSICIAN'S NAME (Type): Dr. William H. Fisher Jr. Medical Center-Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 20, 1959

22c. NAME OF CEMETERY OR CREMATORY: Bethel Church Cemetery-R.D.#(Walston)

22d. LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: SEP 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Travers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10804

10795

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke [illegible]
d. STREET ADDRESS 433 Banks St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: James Middle: E Last: Lewis

4. DATE OF DEATH Month: September Day: 12 Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 23 1885

9. AGE (If years last birthday) 74 yrs.
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Street Cleaner

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hezicar Lewis

14. MOTHER'S MAIDEN NAME: Nettie Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 214-34-5074

INFORMANT: Charles Lewis Address: Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, Accident with

DUE TO (b) Malignant malaria

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 25, 1959, to Sept 12, 1959, that I last saw the deceased alive on Sept 12, 1959, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Rufus S. Gardner M.D. ADDRESS (Street, city or town, state) Pocomoke City, Md. DATE SIGNED 9/12/59

PHYSICIAN'S NAME (Type) Rufus S. Gardner M.D. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 9-14-59

22c. NAME OF CEMETERY OR CREMATORY Red Hill

22d. LOCATION (City, town, or county) Keller, Va. (State)

23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton ADDRESS Nan Church, Va.

24a. REC'D BY REGISTRAR DATE SEP 18 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kana

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10805

CERTIFICATE OF DEATH

10796

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 404 Somerset Ave.,

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 404 Somerset Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle: Lee; Last: Lewis

4. DATE OF DEATH: Month: September; Day: 10; Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 14, 1883

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: 214-12-0394

11. BIRTHPLACE (State or foreign country): Vienna, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Levin Lewis

14. MOTHER'S MAIDEN NAME: Sarah Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address: Miss Gladys Lewis, 404 Somerset Ave., Salisbury, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Degenerative heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1yr
422.1
DUE TO (b): Generalized arteriosclerosis — 1yr
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Severe rheumatoid arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1957, to Sept. 10, 1959, that I last saw the deceased alive on Sept. 9, 1959, and that death occurred at 1:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William D Gray M.D
ADDRESS (Street, city or town, state): 334 Camden Ave Salisbury
DATE SIGNED: 9/10/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept.12,1959
22c. NAME OF CEMETERY OR CREMATORY: Green Lawn Cemetery
22d. LOCATION (City, town, or county) (State): Cambridge, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth R. Thomas
ADDRESS: Cambridge, Md.

24a. REC'D BY REGISTRAR DATE: SEP 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 — 10797

10806

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Md. b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First: Charles Middle: L. Last: Lloyd

4. DATE OF DEATH Month: September Day: 9 Year: 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1-26-1875
9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Lloyd
14 MOTHER'S MAIDEN NAME Anna E. Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N —
16. SOCIAL SECURITY NO
INFORMANT Mrs Lillie Lorimore Address P. Anne Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction — 24 hrs.

4 . 1

DUE TO (b) Hypertensive cardiovascular disease — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Generalized arteriosclerosis — 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign Prostatic hypertrophy, Chronic pyelonephritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p m Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I attended the deceased from Sept 7, 1959, to Sept 9, 1959 that I last saw the deceased alive on Sept 9, 1959, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Raymond M. You M.D. ADDRESS (Street, city or town, state) 707 Camden Salisbury, Md. DATE SIGNED 9-9-59

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 9-11-59
22c NAME OF CEMETERY OR CREMATORY Asbury M Cemetery
22d. LOCATION (City, town, or county) (State) Mt Vernon Md

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] ADDRESS P. Anne Md
24a REC'D BY REGISTRAR DATE SEP 14 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10798

Reg. Dist. No. 10807

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 507 Calloway St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAROLD EUGENE Middle Last Malone
4. DATE OF DEATH: Month 9-15-59 Day Year 19
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 24, 1880
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Malone
14. MOTHER'S MAIDEN NAME: Sally Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: 219-03-5102
17. INFORMANT: Address: Mrs. Elizabeth W. Malone

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Acute congestive heart failure — 12 hours
DUE TO (c): Arterio-sclerotic cardio-vascular disease — Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Found unconscious on street 8:15 A.M. 9-15-59
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9-17-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/18/59
22c. NAME OF CEMETERY OR CREMATORY: Allen Cemetery
22d. LOCATION (City, town, or county) (State): Allen Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The Hill & Johnson Co. Salisbury Maryland
24a. REC'D BY REGISTRAR DATE: SEP 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

· 1 ·

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10799

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10808

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 415 Covington St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marcia — Middle: E. — Last: Manuel

4. DATE OF DEATH: Month: Sept. — Day: 27 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 28, 1959

9. AGE (In years last birthday): ___ yrs. — IF UNDER 1 YEAR: Months: 2 — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Salisbury Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Manuel

14. MOTHER'S MAIDEN NAME: Lucille Coston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Hilda Coston, Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Endocardial Fibroelastosis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Phillip A. Insley M.D.

EXAMINER'S NAME (Type): Phillip A. Insley

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 9-28-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 28/59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Baptist

22d. LOCATION (City, town, or county) (State): Snow Hill Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Norman F. Harris — ADDRESS: Snow Hill Md.

24a. REC'D BY REGISTRAR DATE: OCT 1 '59

24b. REGISTRAR'S SIGNATURE: Arthur D. Kimes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
5M 9/55

20822 12XU3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10836 — Reg. Dist. No. 10800

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marsella
c. LENGTH OF STAY IN 1b: 18 Mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md. — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marsellia
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Adam — Middle: — Last: Metz

4. DATE OF DEATH: Month: 9 — Day: 19 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/7/1882

9. AGE (If years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Ret.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philip Metz

14. MOTHER'S MAIDEN NAME: Elizabeth Maness

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Carl Metz — Address: Marsellia, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart Failure - Dilatation
DUE TO (b): Existed for years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Complete Lack of Vital Force
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 2nd, 1959 to Sept 19th, 1959, that I last saw the deceased alive on Sept 19th, 1959, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred C. Quinn M.D. — ADDRESS (Street, city or town, state): Marsellia, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): FRED C. QUINN — Sept. 22nd 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/22/59 — 22c. NAME OF CEMETERY OR CREMATORY: East New Market — 22d. LOCATION (City, town, or county) (State): East New Market, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth N. Willoughby — ADDRESS: East New Market

24a. REC'D BY REGISTRAR DATE: SEP 25 '59 — 24b. REGISTRAR'S SIGNATURE: S. Truitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10837

10801

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wetipquin
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.F.D#1 Quantico Md. (Home)

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wetipquin
d. STREET ADDRESS: R.F.D.# 1 Quantico Md.
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Danie — Middle: — Last: Moore

4. DATE OF DEATH: Month: Septeber — Day: 18 — Year: 1959

5. SEX: Female
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: August 8, 1879
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lived on a farm
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Dashield
14. MOTHER'S MAIDEN NAME: Emiley Gale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mable Elzey, Nanticoke Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion. — INTERVAL BETWEEN ONSET AND DEATH: 1 hour.

DUE TO (b): Arterio sclerotic Heart Disease. — 10 Years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 20 July, 1959, to 18 Sept., 1959, that I last saw the deceased alive on 18 Sept., 1959, and that death occurred at 10 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Richard H. Saunders M.D. — ADDRESS (Street, city or town, state): Nanticoke Md. — DATE SIGNED: 21 Sept 59

PHYSICIAN'S NAME (Type): Richard H. Saunders — Nanticoke Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 22, 1959
22c NAME OF CEMETERY OR CREMATORY: Odd Fellow
22d. LOCATION (City, town, or county) (State): Wetipquin Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton E. Stewart — ADDRESS: Salisbury Md.

24a. REC'D BY REGISTRAR DATE: SEP 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Knowles

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10809

CERTIFICATE OF DEATH

10802

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ERNEST Middle: W. Last: MORRIS

4. DATE OF DEATH: Month: September Day: 25 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 25, 1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wallace Morris

14. MOTHER'S MAIDEN NAME: Emma Littleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: —

INFORMANT: Mr. Oliver Morris Address: Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MASSIVE GENITO-URINARY Bleeding
450.0
DUE TO
(b): ARTERIOSCLEROSIS - GENERALIZED.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m p. m Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-24, 1959, to 9-25, 1959, that I last saw the deceased alive on 9-25, 1959, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. Gray Rews M.D. ADDRESS (Street, city or town, state): Medical Center - Salisbury, Md. DATE SIGNED

PHYSICIAN'S NAME (Type):

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9-29-59

22c. NAME OF CEMETERY ~~OR CREMATORY~~: EVERGREEN

22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: SEP 29 '59

24b REGISTRAR'S SIGNATURE: Arthur M. Hearn

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G249 10/5/59 jwk

CERTIFICATE OF DEATH

10803 Reg. Dist. No.

10810

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 15 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 717 S. Div. St.,

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 717 S. Div. St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA Middle RIGGIN Last MORRIS

4. DATE OF DEATH: Month 9 Day 19 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 8, 1884/ 1883

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Riggin

14. MOTHER'S MAIDEN NAME: Martha Wimbrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO: 220-32-0788

17. INFORMANT: Miss Dorothy Morris, Same
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Arteriosclerotic Cardiovascular Disease
DUE TO (c): and Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Staphylococcal Cellulitis of Back

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1958 to Sept 19, 1959, that I last saw the deceased alive on Sept 19, 1959, and that death occurred at 4:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr. M.D.
ADDRESS (Street, city or town, state): Salisbury, Maryland
DATE SIGNED: 9/21/59

PHYSICIAN'S NAME (Type): Thos. C. Hill, Jr. M.D. Pine Bluff Rd., Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/22/59
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 24 '59

24b REGISTRAR'S SIGNATURE: Carlton E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10811 — 10804 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ~~Somerset~~ Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Fruitland~~ Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): On Highway#13(D.O.A.Hosp.Sal.Md.)

2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury (Rural)
d. STREET ADDRESS: R.D.# 5(Schumaker Rd)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NINA — Middle MARTHA — Last MORRISON
4. DATE OF DEATH: Month SEPT. — Day 1 st — Year 19 59
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 22,1922
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress-employee
10b. KIND OF BUSINESS OR INDUSTRY: of Restaurant
11. BIRTHPLACE (State or foreign country): Wicomico County, Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Lyman Pottle
14. MOTHER'S MAIDEN NAME: Edna Ruark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Welton Parsons (Mother) Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Compound Fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
812X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Bus minor struck her while Pedestrian
20c. TIME OF INJURY: Hour 12.15 a.m. p.m. — Month, Day, Year 9-1 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt 13 2½ M.
20f. (City or town) (County) (State): N. Pocomoke Worcester Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 2 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 3 /59
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND
24a. REC'D BY REGISTRAR DATE: SEP 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10812

CERTIFICATE OF DEATH

10805

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE MARYLAND — b. COUNTY SOMERSET ✓

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION

d. STREET ADDRESS R.F.D.

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First LEON Middle — Last ONLEY

4. DATE OF DEATH Month September Day 9, Year 1959

5. SEX MALE

6. COLOR OR RACE NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH MARCH 24, 1912

9. AGE (In years last birthday) 47 yrs.

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER

10b. KIND OF BUSINESS OR INDUSTRY FARMING

11. BIRTHPLACE (State or foreign country) VIRGINIA

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE

16. SOCIAL SECURITY NO.

INFORMANT Address MRS PAULINE DENNIS, MARION, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma — INTERVAL BETWEEN ONSET AND DEATH 28 hrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 4, 1959, to Sept 4, 1959, that I last saw the deceased alive on Sept. 4, 1959, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE David Gilmore M.D. ADDRESS (Street, city or town, state) Salisbury Md. DATE SIGNED 9/11/59

PHYSICIAN'S NAME (Type) David J. Gilmore

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b DATE THEREOF 9-12-59

22c NAME OF CEMETERY OR CREMATORY KINGSTON CEMETERY

22d LOCATION (City, town, or county) (State) KINGSTON, MD.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS BRADSHAW & SONS, CRISFIELD, MD.

24a RECEIVED BY REGISTRAR DATE SEP 15 59

24b. REGISTRAR'S SIGNATURE Arthur J. Nunn

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10813 — 10806 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 112 Parsons St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 112 Parsons St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle ODELL — Last PARKS

4. DATE OF DEATH: Month SEPT. — Day 13th — Year 19 59

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐: Single
8. DATE OF BIRTH: July 4, 1920
9. AGE (In years last birthday): 39 yrs.
IF UNDER 1 YEAR: Months 2 — Days 9
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter-Construction-Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: No Record
14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): Mrs. Daisy McCready (Friend) 112 Parsons St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Dr. Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Sept. 14 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 16, 1959
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: SEP 15 '59
24b. REGISTRAR'S SIGNATURE: Carlton L. Truitt

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISME(S) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10814

CERTIFICATE OF DEATH

Reg. Dist. No. 10807

1 PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Res'dence before admission)
a. STATE DELAWARE — b. COUNTY SUSSEX
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DELMAR 4½
d. STREET ADDRESS R.D. # 2
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print) First: Wanda — Middle: — Last: Patilla

4. DATE OF DEATH Month: September — Day: 3 — Year: 1959

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-4-1895
9 AGE (In years last birthday) 64 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Poland
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14 MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: None
INFORMANT: Andy Patilla — Address: Delmar Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diffuse Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (b) Carcinoma - Sigmoid Colon
153.3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:24 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Gray Rees M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 3 Sept 1959

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-5-59
22c. NAME OF CEMETERY OR CREMATORY: Spring Hill
22d. LOCATION (City, town or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Mason & Son — ADDRESS: Delmar, Del
24a. REC'D BY REGISTRAR DATE: SEP 8 '59
24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10815

CERTIFICATE OF DEATH

Reg. Dist. No. 10808

1 PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Trappe
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Francis Middle S. Last Penn
4. DATE OF DEATH Month September Day 9 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 5, 1878
9. AGE (In years last birthday) 80 yrs
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles H. Penn
14. MOTHER'S MAIDEN NAME Mary E. Disney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-24-7437
INFORMANT Mrs. Florence Penn Address Trappe, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 9 days.
DUE TO (b) Nephrosclerosis. — 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 44
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Dehydration. Left posterior tibial artery occlusion
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/2/, 1959, to 9/9/, 1959, that I last saw the deceased alive on 9/8/, 1959, and that death occurred at 8:35 A.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE [signature] M.D.
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept. 12, 1959
22c. NAME OF CEMETERY OR CREMATORY Grace Church Cemetery
22d. LOCATION (City, town, or county) (State) Baltimore Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice F. Newnam Jr. ADDRESS Easton, Md.
24a. REC'D BY REGISTRAR DATE SEP 14 '59
24b. REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10816

CERTIFICATE OF DEATH

10809

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen.Gen Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1023 Spring Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First ANNIE — Middle — Last POLLITT

4. DATE OF DEATH: Month SEPT. — Day 24th — Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb.19,1893
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Sussex Co. Delaware
12 CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Marion James Warrington
14. MOTHER'S MAIDEN NAME: Shanarah Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mr.Marion J.Pollitt(Son) Address: Potomac Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO (b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Phlebothrombosis, left leg
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/26/ 19 59, to 9/24/ 19 59 that I last saw the deceased alive on 9/23/ 19 59, and that death occurred at 4 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: Sept 26/1959

PHYSICIAN'S NAME (Type): Dr.David J. Gilmore — Medical Center-Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept.27,1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND
24a. REC'D BY REGISTRAR DATE: SEP 29 '59
24b. REGISTRAR'S SIGNATURE: Clifton M Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
ISM 9/58

9/23 cm 8/20 cm 9/24 cm

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10817

CERTIFICATE OF DEATH

Reg. Dist. No. 10810

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Roger Middle T Last Powell

4. DATE OF DEATH Month September Day 29 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH July 29 1923
9. AGE (In years last birthday) 36 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Rudolph Powell
14. MOTHER'S MAIDEN NAME Stella Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
INFORMANT Address Mrs. Henry Bailey Princess Anne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cirrhosis of Liver (Laennecs) — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from September 27 19 59 to Sept. 27, 1959 that I last saw the deceased alive on Sept. 27, 19 59 and that death occurred at 11:30 PM, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE David J. Gilmore M.D
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/2/59
22c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian
22d. LOCATION (City, town, or county) (State) Princess Anne Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Howard Timmons Princess Anne
24a. REC'D BY REGISTRAR DATE OCT 7 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A II (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Filed 9-24-59 et

10818

CERTIFICATE OF DEATH

10811

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4½ Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springhill Sanitarium, Inc.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Willards
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Harry — Middle D. — Last Richardson

4. DATE OF DEATH: Month September — Day 12, — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 12, 1888

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter S. Richardson

14. MOTHER'S MAIDEN NAME: Mary E. Parsons

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-14-2493A

17. INFORMANT: Vaughn Richardson Address: Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO (b): 1 " Atherosclerosis — 3 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from 6/29, 19 59, to Sept. 12, 19 59, that I last saw the deceased alive on 9/12, 19 59, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David J. Gilmore M.D. — ADDRESS (Street, city or town, state): Medical Center, Salisbury, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): DAVID J. GILMORE, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/15/59

22c. NAME OF CEMETERY OR CREMATORY: Memorial Park

22d. LOCATION (City, town, or county) (State): Salisbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ellen Wheatley Fuller — ADDRESS: Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: SEP 21 '59

24b. REGISTRAR'S SIGNATURE: Clifton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

X 1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10812

108.9

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela
d. STREET ADDRESS: R.F.D. 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: KARL — Middle: — Last: Richardson
4. DATE OF DEATH: Month: 9- — Day: 16- — Year: 59 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 1, 1892
9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy
10b. KIND OF BUSINESS OR INDUSTRY: Navy
11. BIRTHPLACE (State or foreign country): MAryland
12. CITIZEN OF WHAT COUNTRY?: US.A.

13. FATHER'S NAME: John Richardson
14. MOTHER'S MAIDEN NAME: Unknow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI Navy CBM
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. MAry E. Richardson — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: — a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royer, M.D. — M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 9-17-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/21/59
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.
22d. LOCATION (City, town, or county) (State): Arlington Va.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The Hill & Johnson Co. Salisbury, Md.
24a. REC'D BY REGISTRAR DATE: SEP 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10813

CERTIFICATE OF DEATH

10820 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE MARYLAND b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STOCKTON, Md.
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JOAN Middle ANN Last ROLEY
4. DATE OF DEATH Month SEPTEMBER Day 15 Year 19 59

5. SEX FEMALE
6. COLOR OR RACE NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Dec. 6 1898
9. AGE (In years last birthday) 60 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Roley
14. MOTHER'S MAIDEN NAME LAURA Gunby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-0684
INFORMANT Pauline Manuel Address Stockton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia, Cerebral Edema
DUE TO (b) Loyd minute intracerebral Hemorrhages
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertensive Cardiovascular Disease
INTERVAL BETWEEN ONSET AND DEATH: 2 days ? 443X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/14, 1959, to 9/15, 1959, that I last saw the deceased alive on 9/15, 1959, and that death occurred at 11:50 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE Rufus S Gardner Jr M.D.
ADDRESS (Street, city or town, state) Pine Bluff Rd.
DATE SIGNED 9/15/59
PHYSICIAN'S NAME (Type) Rufus S Gardner Jr Salisbury Md

22a. BUR A., CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Sept. 19, 1959
22c. NAME OF CEMETERY OR CREMATORY Stockton
22d. LOCATION (City, town, or county) (State) Stockton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edgar Wharton — New Church, Va.
24a. REC'D BY REGISTRAR DATE SEP 18 '59
24b. REGISTRAR'S SIGNATURE Arthur S Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10821

10814

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 77 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dames Quarter
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First John — Middle Frederick — Last Shores

4. DATE OF DEATH: Month September — Day 22, — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 9, 1880

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Dames Quarter, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Humphrey Shores

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Watson

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO:

INFORMANT: Mr. C. Thomas Shores (Nephew) Cambridge
Deer's Head Hospital Records--Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: ?

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic heart disease - hypertrophy of prostate, benign

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 7, 19 59 to Sept. 22, 19 59, that I last saw the deceased alive on Sept. 22, 19 59, and that death occurred at 12:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Kosmahly M.D
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 9/22/59

PHYSICIAN'S NAME (Type): G. Kosmahly, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 26, 1959
22c. NAME OF CEMETERY OR CREMATORY: Shores Family Cemetery
22d. LOCATION (City, town, or county) (State): Dames Quarter, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: SEP 29 '59

24b. REGISTRAR'S SIGNATURE: Clarence E. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10822

10815

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md
b. COUNTY Worcester Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin 2 X.
d. STREET ADDRESS Route 3 Berlin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George Middle Lost Smith
4. DATE OF DEATH Month September Day 10 Year 1959
5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-27-30
9. AGE (In years last birthday) 29 yrs. IF UNDER 1 YEAR Months 2 Days — IF UNDER 24 HRS Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Berlin Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Smith
14. MOTHER'S MAIDEN NAME Sadie Selby [redacted]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-34-7250
INFORMANT Rochid Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-10, 1959, to 9-10, 1959, that I last saw the deceased alive on 9-10, 1959, and that death occurred at 2:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE William R. Ellis M.D. ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 9-10-59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION REMOVAL (Specify) Burial
22b. DATE THEREOF 9-14-59
22c. NAME OF CEMETERY OR CREMATORY Germantown Cem.
22d. LOCATION (City, town, or county) (State) Berlin Md.

23. FUNERAL DIRECTOR'S SIGNATURE Barker Dewey ADDRESS
24a. REC'D BY REGISTRAR DATE SEP 16 '59
24b. REGISTRAR'S SIGNATURE Arthur J. Krank

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10823

CERTIFICATE OF DEATH

10816

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [redacted] Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Md
b. COUNTY W[illegible]
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Pocomoke
d. STREET ADDRESS Rt 2 Box 317
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Romona Middle Last Stafford

4. DATE OF DEATH Month Sept Day 13 Year 1959

5. SEX F

6. COLOR OR RACE Col

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Aug 22, 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR Months Days 27 — IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY INFANT

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ike Stafford Jr.

14. MOTHER'S MAIDEN NAME Betty Nicholson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.

INFORMANT Address Ike Stafford Jr., Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Prematurity — 21 Days

DUE TO

(c) Malnutrition — 21 Days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. **I certify** that I attended the deceased from Sept 8, 1959, to Sept 13, 1959, that I last saw the deceased alive on Sept 12, 1959, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE William C. Morgan M.D. ADDRESS (Street, city or town, state) Medical Center Salisbury DATE SIGNED 9/13/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 9/14/59

22c. NAME OF CEMETERY OR CREMATORY St. James Cem.

22d. LOCATION (City, town, or county) Pocomoke City, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton ADDRESS New Church, Va.

24a. REC'D BY REGISTRAR DATE SEP 18 '59

24b. REGISTRAR'S SIGNATURE Arthur L Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

20 4000 19 5X U4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G2h3 10/5/59 jwk

10839

CERTIFICATE OF DEATH

Reg. Dist. No. 1081 [redacted]40

1. PLACE OF DEATH
a. COUNTY Wicomico
MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepstown

c. LENGTH OF STAY IN 1b Life

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepstown Md

d STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First William Middle J Last Stanley

4. DATE OF DEATH Month 9 Day 23 Year 19-59

5. SEX M

6. COLOR OR RACE C

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 1900

9 AGE (In years last birthday) 59 yrs

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Stanley

14. MOTHER'S MAIDEN NAME Alberta Davies

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16 SOCIAL SECURITY NO 216-14-9401A

17 INFORMANT Address Mrs. Stanley

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO
'125X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO
(c) Age

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 19 59 to Sept 24 19 59 that I last saw the deceased alive on Sept 24 19 59, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Fred C Quinn M.D. ADDRESS (Street, city or town, state) Marion, Md. DATE SIGNED Sept 24 59

PHYSICIAN'S NAME (Type) FRED C. QUINN

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF 9-27-59

22c NAME OF CEMETERY OR CREMATORY Shepstown Cem.

22d LOCATION (City, town, or county) Shepstown (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Baker Meech ADDRESS

24a. REC'D BY REGISTRAR DATE SEP 30 '59

24b. REGISTRAR'S SIGNATURE Clifton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10824

CERTIFICATE OF DEATH

10818 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 3 WEEKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD 19 1
d. STREET ADDRESS ASBURY SECTION
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Blanche Middle PRUITT Last Sterling
4. DATE OF DEATH Month September Day 15 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH, Dec. 24, 1889
9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) CRISFIELD, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ELIJAH PRUITT
14. MOTHER'S MAIDEN NAME CORNELIA STERLING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
INFORMANT WM. R. STERLING — Address COLUMBIA AVE & MYRTLE ST. CRISFIELD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 days
332 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-25, 1959, to 9-15, 1959, that I last saw the deceased alive on 9-15, 1959, and that death occurred at 5:40 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE David J. Gilmore M.D
ADDRESS (Street, city or town, state) Salisbury Md.
DATE SIGNED 9/15/59
PHYSICIAN'S NAME (Type) David J. Gilmore

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 9/18/59
22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery
22d. LOCATION (City, town, or county) (State) CRISFIELD, MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bradshaw & Sons - Crisfield, Md.
24a. REC'D BY REGISTRAR DATE SEP 18 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10819

10839 . **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Wicomico MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE Maryland b. COUNTY Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Powellville

c LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Powellville (Rural)

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# Pittsville

d. STREET ADDRESS R.D.# Pittsville

e. IS RESIDENCE ON A FARM? YES X NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MARY	EDNA	THOMAS	Sept.	14th	19 59

5. SEX	6. COLOR OR RACE	7 MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Nov.5,1912	46 yrs.	10	9		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
House Work- School Bus Operator		Powellville, Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Robert A. Dennis	Edna Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
No		Mr. William W. Thomas (Husband) R.D.# Powell-ville, Pittsville, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver (primary

155.0

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
	19					

21. I certify that I attended the deceased from March, 1959, to 9-14, 1959, that I last saw the deceased alive on 9-14, 1959, and that death occurred at 11:55 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Frank Lewis M.D ADDRESS (Street, city or town, state) Willards, Maryland DATE SIGNED

PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis Willards, Maryland Sept /59

22a. BURIAL, CREMATION REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	Sept. 17, 1959	Dennis Family Cemetery-	Powellville (Rural) Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY SALISBURY MARYLAND	SEP 21 '59	Arthur J. Hearn

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 8M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10840 Item 7 Film G249 9-28-59 et — Reg. Dist. No. 10820

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Tyaskin
c. LENGTH OF STAY IN 1b: 1 Year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Quantico Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: 7
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Tyaskin
e. STREET ADDRESS: Route # 1 Box 92
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Richard	Thomas		9-18-59		19

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
M	C		3-13-26	33 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Richard McCall Thomas
14. MOTHER'S MAIDEN NAME: Bernice Green
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II
16. SOCIAL SECURITY NO.:
17. INFORMANT: R. McCall Thomas Address: Thomas, 1226 Boston Road Bronx 56, NY.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Crushed skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Driver of car that crossed white line hit oncoming car

20c. TIME OF INJURY Hour	Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not while at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
7:30 P.M.	9-18-59		Highway	TYASKIN WICOMICO MD.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 9-18-59

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burn	9/22/59	White Haven Cem.	Tyaskin, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: C. T. Messick ADDRESS: Bivalve, Md.
24a. REC'D BY REGISTRAR DATE: SEP 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kimes

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 6248 9-16-59 et

10825

CERTIFICATE OF DEATH

10821

Reg. Dist. No.

1. PLACE OF DEATH, a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 517 Collins Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Julia Middle Last Townsend

4. DATE OF DEATH: Month September Day 3 Year 1959

5. SEX: Female
6. COLOR OR RACE: Colored
7. ~~MARRIED~~ ~~NEVER MARRIED~~ ~~WIDOWED~~ DIVORCED ☑
8. DATE OF BIRTH: Sept 30 1906
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joshua Lawson
14. MOTHER'S MAIDEN NAME: Annie Wooden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 200-09-1184
INFORMANT: Daisy Lawson Address: 517 Collins St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite
260X
DUE TO (b): Diabetes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9/2 1959 to 9/3 1959, that I last saw the deceased alive on 9/3 1959, and that death occurred at 7:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: H. L. Graves M.D. ADDRESS (Street, city or town, state): Salisbury, Md DATE SIGNED: 9/3/59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/5/59
22c. NAME OF CEMETERY OR CREMATORY: Green Acres
22d. LOCATION (City, town, or county) (State): Salisbury Md

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton E. Stewart ADDRESS: Salisbury Md
24a. REC'D BY REGISTRAR DATE: SEP 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10825

CERTIFICATE OF DEATH

Reg. Dist. No. 10822

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: Route 2 Box 15
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Calvin — Middle: Lee — Last: Tull

4. DATE OF DEATH: Month: September — Day: 3 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: September 1 1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: INFANT

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Reuben Vern Tull

14. MOTHER'S MAIDEN NAME: Frances Esther Shockley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Ruben Tull — Address: Snow Hill Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial Hemorrhage
DUE TO (b): Prematurity (1675gms)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: appx 5 hrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 9/1, 1959, to 9/3, 1959, that I last saw the deceased alive on 9/3, 1959, and that death occurred at 5 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Arjuel C. Kalis M.D. — ADDRESS (Street, city or town, state): Medical Center Salisbury, Maryland — DATE SIGNED: 9/4/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL? (Specify): Burial

22b. DATE THEREOF: 9-5-59

22c. NAME OF CEMETERY OR CREMATORY: Wardtown

22d. LOCATION (City, town, or county) (State): Pocomoke Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: New Church, Va.

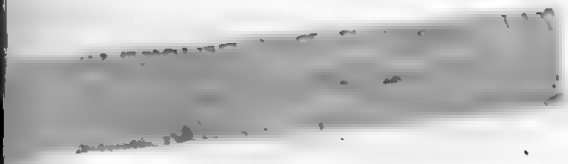
24a. REC'D BY REGISTRAR DATE: SEP 11 '59

24b. REGISTRAR'S SIGNATURE: Cecilia S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

2182211XU2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10841

CERTIFICATE OF DEATH

Reg. Dist. No. 10823

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Home R.F.D.#2 Jersey Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury Jersey Road R.F.D.# 2
d. STREET ADDRESS: R.F.D. 2 Jersey Road
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First: Marih — Middle: E. — Last: Victor

4. DATE OF DEATH: Month: September — Day: 28 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 24, 1896

9. AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lived on farm

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Annie Horten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebral arteriosclerosis — 2

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerotic heart disease decomp. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1957 to Sept 28, 1957, that I last saw the deceased alive on Sept 25, 1957, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Sohler M.D. — ADDRESS (Street, city or town, state): 303 East St. Delmar Md. — DATE SIGNED: 10-1-59

PHYSICIAN'S NAME (Type): L. V. Sohler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/2/1959

22c. NAME OF CEMETERY OR CREMATORY: Mt. Wesley

22d. LOCATION (City, town, or county) (State): Snow Hill Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS:

24a. REC'D BY REGISTRAR — DATE: OCT 7 '59

24b. REGISTRAR'S SIGNATURE: Arthur B. Kelly

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10827

CERTIFICATE OF DEATH

Reg. Dist. No. 10824

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 55 days

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Eden
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Mead State Hospital
d. STREET ADDRESS: Route # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: George — Middle: G. — Last: White

4. DATE OF DEATH: Month: Sept. — Day: 20 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/20/1883

9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George White

14. MOTHER'S MAIDEN NAME: Rachel Tinsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of prostate gland with generalized metastases — INTERVAL BETWEEN ONSET AND DEATH: Years

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 27, 1959, to Sept. 20, 1959, that I last saw the deceased alive on Sept. 20, 1959, and that death occurred at 11:11 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: V Juerman M.D.

ADDRESS (Street, city or town, state): Deer's Mead State Hospital

DATE SIGNED: 9/21/59

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-23-59

22c. NAME OF CEMETERY OR CREMATORY: Green Acres

22d. LOCATION (City, town, or county): Salisbury (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Barker Wallace — ADDRESS:

24a. REC'D BY REGISTRAR DATE: SEP 25 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Trump

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10828 — Reg. Dist. No. 10825

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 20 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 409 Camden Ave.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12. Salisbury
d. STREET ADDRESS: 409 Camden Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SOUTHEY — Middle KING — Last WHITE

4. DATE OF DEATH: Month 9 — Day 25 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept.14,1874

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newspaper

10b. KIND OF BUSINESS OR INDUSTRY: Editor

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward White

14. MOTHER'S MAIDEN NAME: Mary Burbage

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 218-12-1746

17. INFORMANT — Address: Mrs. S.King White, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion, Acute — INTERVAL BETWEEN ONSET AND DEATH: 2 days

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Cardiovascular Dis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/31, 1959, to 9/22, 1959, that I last saw the deceased alive on 9/23, 1959, and that death occurred at 3:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus Gardner Jr., M.D. — ADDRESS (Street, city or town, state): Salisbury, MAryland — DATE SIGNED: 9-28-59

PHYSICIAN'S NAME (Type): Dr. Rufus Gardner, Pine Bluff Rd., Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-28-59

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: SEP 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10829

CERTIFICATE OF DEATH

Reg. Dist. No. 10826

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill 23X-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Nancy — Middle Jr. — Last WYNN

4. DATE OF DEATH: Month SEPTEMBER — Day 16 — Year 1959

5. SEX: FEMALE

6. COLOR OR RACE: COLORED — MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

7. DATE OF BIRTH: March 30-1884

9. AGE (In years last birthday): 75/5/16 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Snow Hill, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Eric Collick

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Mrs Francis Anastacia — Address: 535 Ronkonkoma ave West Hempstead N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism
443X
DUE TO (b): Auricular Fibrillation
DUE TO (c): Hypertensive Cardiovascular Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 14, 1959 to Sept. 16, 1959 that I last saw the deceased alive on Sept. 16, 1959, and that death occurred at 11:20 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hilly, M.D. — ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury, Md. — DATE SIGNED: 9/17/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Sept. 18/59 — 22c. NAME OF CEMETERY OR CREMATORY: Baptist Cemetery — 22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Allan E. Timmons — ADDRESS: Snow Hill Md

24a. REC'D BY REGISTRAR DATE: SEP 21 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58